

Equity and Quality; Issues In Universal Health Care

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July 2001

Overview

This paper reviews principles and concerns surrounding equity and quality in health care, discusses competing views and agendas in establishing guidelines, and suggests frameworks for clarifying process and goals. Discussions are philosophical and political; definition and criteria continue to be elusive. Does equity imply freedom of choice or equal care? We make assumptions and speak past each other in considering what equity and quality are and how to achieve them. Equity is not the same as equal, and we do not often acknowledge the inevitability of inequality. No system of health care can achieve equal health status for its citizens. Much ill health is due to social circumstances including poverty, poor housing and nutrition, lack of employable skills, and any system must distinguish between medical, social, and psychological need. In addition, these factors interact, and it is often impractical to differentiate. Poverty and lack of health insurance predict lack of insurance coverage and access to primary care and prevention services. Care for the poor tends to address urgent needs, the quality of that care is highly questionable, and recommended treatments are often based on expediency rather than appropriateness. Good health care does contribute to health, and good health is a precondition to quality of life. We are concerned with access to care required for persons to be effective participants in society. In particular we are concerned with the inequity of one in five adults under the age of 64 and the one in three to four children¹ without health insurance. (Brown, Ninez and Rice 2001; Wulsin and Frates 1988) Our duty to their well-being has profound implications for access to care. We are also concerned with the quality of care for those who do access the system. If utilization of health care is not significantly associated with better outcomes, perhaps a major component is the quality of that care. Thus, primary questions are, "Which inequalities are inequitable?" and "What measures and values do we count?"

Need

Universal health care is intended to provide access to care for an entire identified population. Having said that, we need to define and operationalize equity and quality, and we must identify the essential components of a system that is equitable and meets standards of care. We must also address the decision-making process and address questions of what and how much care, who is our population, what interventions affect health status, and what measures and standards count. These ethical and practical details have a strong, direct effect on quality and cost. We accept the premise that once the price of a service is free or significantly reduced, demand will increase; it is not clear that demand will be appropriate, equitable or of acceptable quality. Therefore, the traditional cyclical impact of access on cost on quality remains problematic.

¹ Reports differ depending on the sample and other study differences.

Several ethical principles and norms guide rhetoric and policy in designing health care systems and in providing care. The most obvious is the concern for justice in the distribution of resources. However, we do not have consensus on the criteria, the measures, nor the goals of justice. Applying the traditional maxim, Vladek suggests “equity is an attribute of a system that provides roughly similar services to those with similar health problems, and appropriately dissimilar services to those with dissimilar problems.” He acknowledges the limitations of this construct, including the absence of agreement regarding similarities and appropriateness. (Vladek 1981) Aday and Anderson (1981) have suggested equity of access exists when services are consistent with individual need. However, the concept of need continues to elude clear measures, and determination of need has become a moving target. Physicians are no longer the sole arbiters of necessity.

Values are framed vaguely and may conflict. Do we strive for equal access, equal health care or health status? The former is problematic; equal care is inappropriate, and equal health status is not possible. Notions of desert, need, and ability to pay have imposed economic constraints on the ethical mandates, and the identified patient is the default object of good and right action. Given the American preoccupation with liberty rights, we have not articulated or prioritized communal values nor translated them into political decisions. Thus, we perpetuate the cyclical tradeoffs among cost, quality and access to care. Under universal health care, without limitations to benefit structure or ability to pay, demand will increase and may include requests for remedies of questionable efficacy or that are discretionary or enhancement rather than treatment. Resources are inadequate to address all the wants as well as the needs. However, the distinctions between physical and mental, therapy and enhancement, preferred and essential are challenges to equity, to cost, and to quality. This paper argues that each condition is necessary but not sufficient; clear and fair public policy with meaningful, reasonable standards is necessary to support all three goals. Assuming consumer/patient participation and voice in deliberations regarding universal coverage, the challenge is to identify and construct a system that meets standards of equity and quality, and to implement process necessary to safeguard those critical values.

In its seminal work, the President’s Commission identified as necessary that health care which protects and allows the experience of life’s opportunities, goods, and physical well-being, relieves worry and relates to the “interpersonal significance” surrounding illness, birth and death. The Commission did not see equitable access as “everything needed” nor “everything beneficial” nor “everything that anyone else is getting.” They concluded that the special nature of health care dictates that everyone have access to an adequate level of care, which they defined as “enough care to achieve sufficient welfare, opportunity, information, and evidence of interpersonal concerns to facilitate a reasonable full and satisfying life.” This implies that not all beneficial care is necessary in order to achieve equity. It is also important to differentiate between unlimited care and unlimited treatment.

The Scope of the Problem

The relationship between health care and health. “In developed countries, the marginal contribution of medical care to life expectancy is very small.” (Fuchs 1998) Many critical factors associated with poor health may be outside the health care system. Universally, the

poor are sicker, and inequalities in health persist in industrialized countries with universal financing systems designed to provide equal access. Great Britain, Sweden, Finland, Holland, and the World Health Organization extensively documented large and often increasing gaps in health status and social and economic parity. There is growing recognition that these health disparities cannot be explained by differential access. Gunning-Schepers and Stronks (1999) note “differences in health between social groups, defined by class, educational level, income or professional status have been recorded in every country that has carried out research and have not visibly diminished despite social policies such as universal access to health care, greater access to educational opportunities, occupational health efforts, or reductions in income inequality.” In the United States, differential access for the poor through Medicare, Medicaid, and private health insurance persists. Vladek reported government cost-containment policies have had a differentially greater impact on the poor. (1981) However, in a recent report, Ross and Mirowsky (2000) note the poor use more health services because they are sicker; their health status is independent of insurance coverage although poorest health is observed among Medicaid recipients. Health problems are correlated with other life stresses. Ross and Mirowsky noted that potentially reduced economic hardship from having health coverage might indirectly improve health status.

Along with the relationship between poverty and health, is the growing recognition that universal differences in mortality and morbidity are associated with education, literacy, and income. (Fuchs 1998) However, there is no public consensus about which services would improve health status, but class injustices in health persist. (Marchand, et. al.1998) For example, while reporters agree that the disparity between health status among Whites and African-Americans would remain after adjusting for infant mortality; race, ethnicity and income were also associated with morbidity and functional limitations and fewer preventive services. There is no clear mandate about which interventions would be effective. Black males have a higher mortality rate than white males at each income category, (La Viest et al 2000) and the Medicare black/white mortality rate was 1.6 times higher in 1995 than in 1950. (Williams 2000) Racial disparities in life expectancy among Medicare patients generally were higher in 1996 than in 1950. (Gornick 2000) In England, the infant mortality rate in the lowest socioeconomic class is double that of the highest class. That has not changed since the implementation of the National Health Service. (Whitehead 1999, Ross and Mirowsky 2000, Gunning-Schepers, and Stronks 1999, Brown 1999, Fuchs 1998)²

² Mellor and Milyo (2001) argue the association between inequality and health is more limited than is usually acknowledged based on cross-sectional vs. time series data. They also adjust for smaller geographic units and controlling for household income. While they do not dispute association between health status, income, education, economic changes, technology and government policy, they challenge cause and strength of the association. They question other underlying factors that simultaneously affect health and inequality. In response, House (2001) cites extensive data, including the Black report of the British NHS citing large, increasing disparities in health associated with socioeconomic status, race and ethnicity. House and Kawachi and Blakely (2001) applaud Mellor and Milyo for analysis of the relationship between income equality and health, but all respondents plead for increasing investigation into factors associated with social, economic, and health inequalities.

The problem extends beyond the usual boundaries of health services. In fact, access may not be corrected under universal coverage due to time costs experienced by workers without sick leave, language barriers, isolation and physical difficulty in availing oneself of services, distance, transportation, consumer information, culture, time preferences (the rate at which people discount the future relative to the present), self-efficacy, poor lifestyle, and genetics. Unemployment appears to have a significant, widespread association with poor health although the direction of the association is not clear. Educational level is a strong covariate with health as well as poverty and employment. (Fuchs 1998, La Viest et al 2000) Systemic factors identified with poor access under universal coverage are distribution of health care professionals and differences in medical custom by small geographic area.

Competition among groups for limited resources. Given demand for limited resources within the health care system and other sectors of the economy, some observers believe current services might not provide benefits commensurate with costs. However, between 80 –85% health care is still driven by the physician who may be biased toward his or her particular intervention and consented to by the patient. The high cost of care affects the relative spending for health care as compared with the environment, other personal needs such as proper nutrition and housing. Obviously, different special interest groups advocate in their own interest, and we have not seen data-driven, collaborative programmatic efforts. There are many distinctions that may give rise to competition: age groups, research vs. treatment vs. prevention; diseases; the disabled and persons with chronic illness vs. acute or high tech need. Competition is also a factor in appropriate location for care; treatment settings carry different costs and benefits to quality of care and quality of life. For example, reducing hospital insurance coverage for rehabilitation after a stroke has resulted in shift of patients to long-term care facilities not staffed or equipped to provide the same therapies.

Fuchs (1998) notes that in any one year, 5% of the population accounts for more than 50% of all health expenditures. More than one-third of all care is provided to persons over 65 years of age. Is that inequitable or simply a response to medical necessity? Intergenerational equity has become a rallying cry from several quarters including those who perceive children's needs are disadvantaged. The increasing age of the population provides several challenges to the health care system. Age is a threat to equity due to the pressures from increased costs. The increasing proportion of the elderly results in fewer younger persons to care for the aged or pay into the system. Finally, there is tremendously increased risk of disability and illness among the very old. Fuchs points out that the US spends more on the aged than other nations, particularly for those over age 80. High tech interventions do seem to make a difference; persons who live to be 80 in the United States have the world's second greatest life expectancy. However, allocation questions surround the quantity and type of care. Beyond some age, every part needs replacement or rehabilitation. What are the limits of coverage for diagnosis and treatment? What are the limits of our obligations to address the unequal desires of individuals? If we can "fix it" are we obligated to do so, even if benefits are marginal and other body organs are at risk?

Who decides? Except for the State of Oregon, we have had very little public conversation about universal health care, and Clinton's political discussions were held largely in secret.

Decisions to buy particular benefit packages are largely negotiated between employers and insurance companies.

Physicians have been the gatekeepers at the level of the individual patient. Providers believe their services are critical and essential; their values may differ from the patient, and they almost certainly will not be entirely congruent with the community. While physician and other profession/provider buy-in is crucial to an equitable system and certainly to good quality of care, the consistent focus has been on the identified person. The community without resources or access has been relatively invisible. Certainly, they have not been identified as a moral obligation. There is also much uncertainty in medical practice. The notion that denial of care or benefits can be justified for the common good underlies much of the current utilitarian calculus of managed care, population-based medicine. This is resisted by physicians in treating the individual patient. It is they who make the allocation decisions. Loewy (1996) argues that physicians who are told that they are obligated to do all they can for their particular patient but are also told that they must simultaneously conserve communal resources are being given a set of internally contradictory instructions. How should we define physicians' obligation to practice within a social context, or game the system, if they feel regulations are unfair to the individual patient or force them to ignore evidence-based medicine? The ethos of patients and physicians has been a liberty-based emphasis on the individual, with little attention to the community. Each must be accommodated. Where interests conflict, the boundaries must guarantee socially acceptable ethical standards, derived through a public process. While focus on the public health may ignore the needs of individuals, a model that excludes individual needs diminishes opportunities for normal human function.

Which inequalities are inequitable? Millions of Californians do not have health insurance; approximately one in three California adults under the age of 64 work and do not have health insurance. These persons have little prospect of acquiring health insurance through private payment or through their jobs that are usually in small companies and often in the service sector. Some estimate that another several million persons are underinsured because they cannot afford the out-of-pocket costs for the cost sharing that would accompany care seeking. This lack of coverage affects peace of mind, ability to predict necessary expenditures and provide for other basic goods, and it clearly postpones care seeking. These people are less likely to have a regular source of care, a fact that has implications for timeliness and quality.

It is beyond the scope of this paper to settle the essential questions surrounding state/social responsibility to address questions of the degree to which we are obligated to address inequalities due to social conditions that lead to ill health. Health care has been seen primarily as a precondition to life's other goods; it is a means to restore health, prevent disease and disability and maintain normal human functioning. (Daniels 1985, Buchanan et al 2000) Health care is also valued partly for the validation and caring services that it provides. (Fuchs 1998, Vladek 1981) The predominant traditional view has identified health needs to include injuries, diseases and other conditions that affect normal human functioning. These conditions were seen beyond human blame and health care was critical for relief of pain, recovery and access to opportunity. However, the equation has shifted. Technology has blurred the distinctions surrounding the definition of normal, increased the range of choices, and provided

patients with opportunities for medical treatments of uncertain benefits and harms. Indeed, in rare cases we question the meanings of disease and diagnostic classifications.

Because we can, do we now also have a duty to correct for the social/physical lottery and genetic disability? To what benefits are we entitled? One perspective of the dilemma has focused on a distinction between reasonable treatment goals and futility; another frames discussion around differences between therapy and enhancement. In their discussion of genetics and justice, Buchanan, et al (2000) explore the limitations of the latter distinction. They lead us to ask if the distinction between treatments that address disease and dysfunction are inherently more qualified for coverage under a universal system than enhancement to correct a genetic impairment. We hear their concerns that if access to some genetic interventions is only available to the rich, existing inequalities in opportunity might be made worse, making the playing field more rather than less uneven. On what basis can we categorize some genetic interventions as worthy or not worthy of coverage under a universal system? For example, depending on the cause, growth hormones may be seen as enhancement or therapy.

We have not clarified our obligation to include genetics testing and treatment in an equitable system. Would universal health care include an obligation to correct for the genetics conditions that alter functioning? If we are no longer subject to "bad luck" through a social or natural lottery over which we had no control or choice, do we have a duty to change if we can? Does can mean ought? As an example, Buchanan et al (2000) ask, given an opportunity to prevent Alzheimer's disease through genetic manipulation, is the person with the disease now seen as a victim of injustice rather than misfortune? Are we then obligated to include these services in a universal system? If we can change personal characteristics such as IQ and body height, where does the system's obligation to pay for genetic alteration end? What is our obligation to the poor and to the uneducated for access to these data, to educate them about the potential and the impact of genetic information and for informed choice?

The futility arguments are the flip side of patients' rights debates. The concept of futility in health care is a relatively new effort to regain control for the professional in the face of unrealistic patient or family demands to continue care deemed inappropriate. Demands for inappropriate care are a distortion of patients' rights. Given the discomfort and uncertainty associated with framing options, unrelenting hope particularly at the end of life, and increased numbers of very old patients, the health care system is increasingly challenged with demands to continue aggressive technology. The system has not adapted procedures or language of palliation and comfort measures.

We do not and probably cannot accurately estimate our control over health and illness, or our powers to change ourselves, nor can we predict the extent or time period of changes that do occur. We do have ample evidence of our failure to respect unintended consequences of our behaviors or of health care interventions. Are we therefore responsible or blameworthy for our illnesses, our nonadherence, or even our self-destructive behaviors? That is an ethical question, and it is relevant to benefits structures. Should we decide that persons who smoke and have a coronary or that persons who refuse insulin and experience secondary problems will or will not be covered under our benefit structure? The question is further complicated by

our inability to determine the relative power of lifestyle changes, health care or prayer to prevent or correct for those conditions. It is an exercise in establishing boundaries. Data are useful in circumscribing the issues, but value judgments and ethical principles will be critical to obtain consensus on how much disability is tolerable and what is reimbursable.

We will need to determine which services are basic and essential, which are discretionary, and which need not be supported in a universal system. Should non-covered services be available for private purchase before all basic services are provided? The State of Oregon provides the only US example of an attempt to address these questions through public dialogue, consensus and legislation. They addressed a segment of the public sector, and many regarded that as a fundamental inequity. However, it was intended that the principles and coverage would apply to the entire population, including those who receive health insurance through the workplace. Thus, the Oregon process and the target group provide limited comparison.

Quality. If we expand the depth and breadth of covered conditions, costs increase, and we jeopardize quality and equity through substituted nonprofessional personnel, less intensive technology, greater cost-sharing, or similar devices. Quality has been defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Lohr 1990) Schuster, McGlynn and Brook (1998) identify quality with providing patients with appropriate³ services in a technically competent manner, with good communication, shared decision making, and cultural sensitivity.

Quality measures have traditionally examined structure of services, process of care, and/or selected outcomes. We continue to wrestle with the relationship between process and outcomes as well as the relative value of the caring function including sympathy and reassurance and validation provided by caregivers. Minimal quality standards are addressed through guidelines that attempt to combine science, practice, peer acceptability, and common practice. However, there is a difference between providers, patients and funders views of quality. This difference is more pronounced when it includes amenities associated with care as well as the effects on health are included in the definition. (Fuchs 1998) Accurate measurement of quality must take into account the likelihood of a good outcome and who defines the good. Measurement and value are not synonymous. Quality of life years is determined by the individual; we need to develop some common language or evaluation tool.

What have we found? After an extensive literature review, Schuster, McGlynn and Brook (1998) reported that perhaps their most striking finding was the “small amount of systematic knowledge available on the quality of health care delivered in the United States. However, the evidence repeatedly showed quality fell short of standards. In 2001, McGlynn and Brook described substandard quality of care in the US: “Only half of the population receive needed preventive care; 70% receive recommended care for acute problems such as colds or stomach pain; and just 60% of those with a chronic illness such

³ Brook et al (1986) have written that an intervention or service is considered appropriate if its expected health benefits exceed its expected health risks by a wide enough margin to make the intervention worth doing. Note even the uncertainty, probability and value-laden language that inevitably accompany the best efforts to operationalize these complex topics.

as diabetes or hypertension get the care they need. On the other hand, about one-third of the care delivered for acute problems is not needed (for example antibiotics for the common cold) and may actually be harmful. About one-fifth of the care given to persons with chronic conditions is also unnecessary and possibly harmful. Given the public outcry over a few deaths from bad tires, the lack of public outrage over thousands of preventable deaths in medicine is astounding.” Potential explanations for this lack of response offered by McGlynn and Brook include diffuse responsibility, cognitive dissonance, outmoded system design, information void, and the tendency to shoot the messenger. Clearly, health care has lagged behind industry in quality, and the industry has been slow to acknowledge error⁴ whether in the form of slips, lapses, or mistakes. Coye and Detmer (2001) suggest providers have not had to compete based on quality.

Strategies to improve. McGlynn and Brook (2001) recommend creating “quality champions,” developing a functional information system, routine monitoring and reporting on performance, and ensuring adequate funding for quality measurement. In exploring strategies for improving quality of care for coronary heart disease in the US and England, Ayanian and Quinn (2001) reported on clinical guidelines; national standards; performance reports; benchmarking, feedback and professional leadership; and marker-oriented approaches. Clinical guidelines have not demonstrated effectiveness in changing physicians’ behavior and “inappropriate care remains common.” Without a national health care system, the US hasn’t the mandate or means to implement national standards; public release of performance reports have had limited impact. They regarded benchmarking, feedback, and professional leadership as potentially useful tools to promote quality improvement at the local level. They recommend developing systems of care that promote quality, standardized information gathering and dissemination, greater financial and non-financial incentives by public and private purchaser, and the culture of the health care organization itself is critical. Strategies continually highlight the importance of accountability, information systems, organizational culture, reduction of bureaucratic complexity, and incentives to improve the quality of care. Incentives of payers, providers, patients and the public should be aligned to address quality and reduce error.

Implications for Policy Makers

Both equity and quality depend on providing arrangements that foster ethical gate-keeping, respect appropriate care, address social as well as individual needs, and reward correct incentives.

1. Structure: The poor suffer many inequities; these structural guarantees would address equity as well as quality: an integrated system with minimum standards of benefits with periodic upward adjustment (Fuchs 1998), decentralized delivery, capitation payments, rational supply of physicians; greater use of appropriate physician extenders, and rational hospital utilization.
2. Given the problematic relationship between health care and health, justice requires we consider alternative spending on other needs, research, technology vs. rehabilitation, personal care, and comfort when the illness is not reversible.

⁴ Error, as used by the Institute of Medicine and reported in Becher and Chassin (2001) is “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.”

3. Assess and distribute care locally relative to the needs of the local population.
4. Reevaluate allocation of public health measures that reach larger groups and prevent need for acute interventions further down the line. Prevention, rehabilitation and reassurance have not been as emphasized or well reimbursed as urgent or acute care. In designing the optimal system, these functions must be respected.
5. This longer time frame has not been attractive to private insurance companies who need to meet a short-term bottom line; it is critical to equity and quality in a system of universal care.
6. Given the paucity of data about causes of disparities in access, conduct ongoing data assessment and review existing data to develop short and long-range strategies.
7. Quality and equity require financially neutral decision making at the bedside. Difficult rationing decisions should not be made at the bedside; extensive public discussion, education and conversation with patients, and policies regarding standards of appropriate care should be developed and supported.
8. Public dialogue is critical.

We expect the health system to take care of sick people whether or not they are going to get better, as much for our benefit as theirs. (Vladek 1991 in Fuchs 1998) It is clear we do not know the degree to which the failure of access to correct for health inequalities is due to poor quality of care. In the US, we are likely to offer and receive high tech and more expensive treatments; Americans are likely to operate, dialyze and otherwise intervene in treating the very old. The limitations of that approach for chronic illness are increasingly apparent; the increasing popularity of alternative treatments is one piece of evidence. We must provide care which is acceptable, appropriate, available, and affordable, but unless we do so with attention to the technique, the service and the amenities of care, we will not achieve improvements in health status that mark a successful system.

We have imperfect information about the impact of universal health care on demand and true need, making it even more difficult to construct a tight model of equitable distribution. We do not know how our citizens would fare if only appropriate services were provided in a timely manner and with excellent quality.

Ultimately, the public and its representatives will have to decide and negotiate how we can provide universal coverage, equitably across individual and groups, while observing quality standards, acceptable to the professions and the public, within a socially approved budget. The opportunity is priceless, but it is no longer a luxury.

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*Recommended reading.

This paper was prepared for the California Health and Human Services Agency's Health Care Options Project under the direction of the California Research Bureau. Funding for this effort was provided by a grant from the Health Resources and Services Agency of the U.S. Department of Health and Human Services.